IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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PHONE 208-334-6626
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16 June 2006

Rex Redden, Administrator
Idaho Falls Group Home #4
275 Ash Street
PO Box 50457
Idaho Falls, ID 83405

RE: Idaho Falls Group Home #4, provider #13G071

Dear Mr. Redden:

This is to advise you of the findings of the Medicaid/Licensure survey, which was concluded at your facility, Idaho Falls Group Home #4, on 2 June, 2006.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing

your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **29 June, 2006**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

SHERRI CASE
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

SC/BJT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 (SUMMIT)	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The surveyor conducting your recertification survey was: Sherri Case, LSW/QMRP Common abbreviations used in this report are: AQMRP - Assistant Qualified Mental Retardation Professional BMP - Behavior Management Plan IPP - Individual Program Plan	W 000	RECEIVED JUL 10 2006 FACILITY STANDARDS	
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on review of accident/incident reports, record review, and staff interview, it was determined the facility failed to ensure significant events were promptly reported to the parents and/or guardians for 6 of 6 individuals (Individual #1 - 6) whose accident/incident reports were reviewed. Family and guardians were not informed or were late in being informed of significant incidents. This resulted in the potential lack of advocacy for individuals by parents/guardian. The findings include: 1. The guardian notification sheet for Individual #1, signed by the guardian on 3/3/064, stated she	W 148	**W148** 1. The notification of parents are to be done and documented on th back of all I an A's The form has only one small are to mark date and time. This form will be revised a slot to enter time date and other important information will be added to the form to ensure that it is all documented in A timely manner. 2. This had the potential to affect all residents in the homes and this new revision will go into affect for the entire organization and all facilities will use the new revised form. 3. Training will be provided for all of the supervisors as to when they must call a parent, guardian, or administrator and how to document this on the new revised form. 4. The new I and A forms will be reviewed daily by the supervisor when they are in the home to ensure that notification is occurring and is documented. The AQMRP and/or the QMRP will review the I and A's at least weekly or more frequently, when every they are in the home, to ensure that the supervises is following the proper procedure, and that all forms are filled out in their entirety and notification has happened as specified. 5. The form has been revised and the new form was put in place on 6-6-06.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 7-5-06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 148	Continued From page 1 would like to be notified of any significant behavioral changes. - On 6/9/05 , the time documented as a.m. and p.m., Individual #1 was swinging his arms and legs, and kicking and hitting himself causing a discoloration. The guardian was notified on 6/10/05, however the time contacted was not documented. - On 4/20/05, while at school, Individual #1 had a behavior which caused "bum (sic) scratched, knee red, elbows red." The guardian was contacted on 4/21/05,however the time contacted was not documented. 2. Individual #4's guardian contact sheet, signed 3/3/06, stated she wanted to be notified of any client to client altercations with injury. - On 8/24/05, at 3:30 p.m., Individual #6 grabbed Individual #4 and "scratched" his arm. There was no documentation the guardian was notified. 3. Individual #3's guardian contact sheet, signed 3/3/06, stated she wanted to be notified of any small scrapes or bruise or minor injury of any kind. - On 3/25/06 , at 3:30 p.m., Individual #3 had a behavior and bit his hand until it bled. A message was left for the guardian on 3/27/05, however, there was no further documentation of informing the guardian of the incident. - On 10/12/05, at 4:00 p.m., Individual #3 had an unknown injury of "scratches or rug burn" under his left elbow. A message was left on 10/13/05,	W 148		

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W 148	Continued From page 2 however the time or a follow up call was not documented. 4. Individual #6's guardian contact sheet, signed 3/2/06, stated she would like to be notified of any significant behavioral changes. - On 12/1/05, at 9:00 a.m., Individual #6 had "hit head 15 times" on the van window. The guardian was contacted on 12/2/05, however there was not documentation of the time contacted. 5. Individual #2's guardian contact sheet, signed 9/26/05, stated he would like to be notified of out of the norm doctor appointments or unusual developments. - On 1/10/06, at 2:30 p.m., Individual #2 was taken to the doctor after he fell while washing trays at school. The guardian was notified on 1/11/06, however the time was not documented. - On 11/20/05, at 2:15 p.m., Individual #2 fainted after dental work. The guardian was notified on 11/21/05, however the time was not documented. 6. Individual #5's guardian contact sheet, signed 3/7/06, stated she would like to be notified of small scrapes or bruise or minor injury of any kind and significant behavioral changes. - On 8/26/05, at 3:30 p.m., an unknown injury of five scratches was noted on Individual #5's stomach. There was no documentation the guardian had been contacted. - On 12/04/05, at 7:15 a.m., Individual #5 was	W 148		

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W 148	Continued From page 3 noted to have an unknown injury of a dime size bruise on his upper left arm. A message was left for the guardian on 12/05/05 and the call returned on 12/6/05. A review of the facilities Suspicious or Unknown Injury policy stated the "home supervisor will attempt to contact the resident's guardian /parent if this is indicated on the parent/guardian contact list within 24 hours and document this on the injury report. If the home supervisor is unable to reach the parent/guardian they will try again the following day." During interview, on 6/1/06 at at 2:50 p.m., the house manager showed the surveyor a calender she had kept, since September 2005, documenting conversations with the parents/guardians. The calender had guardian names written on days of the week but no further information was given, such as the time or nature of the call. The AQMRP stated the incident report forms needed to include an area to document the time the guardian was contacted to verify contact had occurred within 24 hours of the incident. She also stated there was not documentation of guardian contacts regarding the incidents prior to September. The lack of notification, documentation of time contacted and late notification for all Individuals' guardians of significant incidents had the potential to result in a lack of advocacy. The facility failed to follow the policy as written regarding the parent/guardian contact list.	W 148		

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W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of the individuals' IPPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 2 of 2 individuals (Individuals #1 and 2) reviewed, who received behavior modifying drugs. This resulted in individuals receiving behavior modifying drugs without plans that identified drug usage and how they may change in relation to progress or regression. The findings include: 1. Individual #2's IPP, dated 9/26/05, documented a 18 year old male diagnosed with schizophreniform disorder with mild to moderate mental retardation. His physicians orders, dated 4/3/06, documented he received Abilify 15 mg and Trazodone 100 mg every evening. Individual #2's Medication Reduction Plan, dated 9/26/056, stated upon admission Individual #2 was taking Imipramine 25 mg and Abilify 7.5 mg at bedtime. The plan stated after Individual #2 was seen by the physician a medication plan would be developed. When asked if this was the most current medication reduction plan the AQMRP stated a medication plan had not been	W 312	W312 1. Individual # 2's medication reduction plan will be revised after consultation with the doctor revisions will be made. Individual # 1's medication reduction will be revised to include only the behaviors that are an issue for reduction of the medication. This will be discussed with this doctor in order to make the revisions. 2. This has the potential to effect all clients in the home. Each behavior reduction plan will be reviewed with the doctor as apointments are scheduled and revisions will be made in order to ensure that we are working on the correct behaviors. Medications being used and medications needing to be reduced first will all be listed on the medications reduction plan. 3. Each medication reduction plan will be reviewed by the AQMRP and/or the QMRP to be sure all aspects of the plan are complete and correct. Each time a medication change is made the medication reduction plan will be reviewed again and changes and updates will be made. 4. The AQMRP and/or the QMRP will review and monitor changes with the help of the behavior specialist. Each medication reduction plan will be reviewed by the behavior specialist each time a medication is changed. 5. To be completed by July 31, 2006	

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W 312	Continued From page 5 implemented for the current prescribed medications. The facility failed to ensure Individual #2's medication reduction plan contained sufficient accurate information. 2. Individual #1's IPP, dated 4/21/05, documented a 20 year old male diagnosed with Williams's Syndrome with autism, and severe mental retardation. His Medication Reduction Plan, dated 4/27/06, stated he received 100 mg Luvox and 15 mg Zyprexa daily for impulse control and aggressive behavior. The plan stated as Individual #1's behaviors decreased a medication decrease would be discussed. The behaviors identified were appropriate vocalizations, decreased aggression, decreased rocking and decreased inappropriate flushing of the toilet. It was unclear if all behaviors listed needed to be decreased. When asked the AQMRP stated aggression was the only the behavior identified.	W 312		
W 370	483.460(k)(3) DRUG ADMINISTRATION The system for drug administration must assure that unlicensed personnel are allowed to administer drugs only if State law permits. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure medications were administered only by licensed	W 370	W370 1. Objective will be added to the plan to have client number one assist with hand over hand assistance to give his nasal spray and his face cream. A plan sheet will then be added to give staff specific instruction on how they are to assist with this medication. 2. This has the potential to affect all clients in the home. all medication regimens will be reviewed and objectives and plan sheet will be added as needed to ensure all clients are helping with all of their medications.	

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W 370	Continued From page 6 personnel in accordance with state law for 1 of 3 individuals (Individual #1) observed receiving medications. This resulted in medication being administered contrary to State law. The findings include: Individual #1's IPP, dated 4/21/05, documented a 20 year old male diagnosed with Williams's Syndrome with autism, and severe mental retardation. His physicians orders, dated 4/18/06 included orders for Astelin nasal 137 mcg and Cleocin T 1%. During observation of medication administration, on 5/31/06 at 7:50 a.m., staff were observed to pour Individual #1's oral medication into a medication cup, hand the cup to him and he took the medication. Staff then opened a bottle of Cleocin T 1% and put it on Individual #1's face. Staff then sprayed Astelin nasal spray into each nostril of Individual #1. Staff were not noted to elicit Individual #1's participation when administering the Cleocin or the Astelin nasal spray. During interview, on 6/1/06 at 3:50 p.m., the AQMRP stated staff should have used hand over hand assistance to administer the above medications. Idaho Board of Nursing Rules, 23.01.01.490.05., state unlicensed personnel may assist individuals with medications, but are not permitted to directly administer medications.	W 370	3. Review will be made of all medication when implemented to be sure they will fit into the current objectives and if they will not then a new objective will be implemented at that time. 4. The AQMRP and/or the QMRP along with the nursing staff will monitor when ever a medication is changed to ensure it will fit into the current objective. If not a new objective will be written into the plan by the QMRP. 5. Review of all medication regiments and new objectives added as needed will be completed by July 31 2006.	

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W 479	483.480(c)(1)(iii) MENUS Menus must be different for the same days of each week and adjusted for seasonal changes. This STANDARD is not met as evidenced by: Based on a review of the facility's menus and interview, it was determined the facility failed to ensure menus were reflective of seasonal change for 6 of 6 individuals (Individual's #1 - #6) residing at the facility. This resulted in the potential for individuals not to receive a full variety of foods in accordance with the season. Findings include: 1. The facility's menu was reviewed on 5/30/06 at 6:30 p.m. The menu for the evening observation included chicken patties, mashed potatoes, gravy, canned peas and apple cobbler with ice cream for dessert. When the house manager was asked if the menu had changed for the summer season she stated it had not and the same series of menus were rotated throughout the year. The AQMRP stated, on 5/31/06, the menus did not reflect seasonal changes and the current menus had not been changed for over two years. The facility failed to ensure menus were reflective of seasonal change.	W 479	3. Review will be made of all medication when implemented to be sure they will fit into the current objectives and if they will not then a new objective will be implemented at that time. 4. The AQMRP and/or the QMRP along with the nursing staff will monitor when ever a medication is changed to ensure it will fit into the current objective. If not a new objective will be written into the plan by the QMRP. 5. Review of all medication regiments and new objectives added as needed will be completed by July 31 2006. 7/13/06 – 3:20p.m. Phone call to Mary – she will fop correct information Sherri Case	

Bureau of Facility Standards

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MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312	MM197	SEE W312	
MM231	16.03.11.080.03(a) Informed of Activities To be informed of activities related to the resident that may be of interest to them or of significant changes in the resident's condition; and This Rule is not met as evidenced by: Refer to W148	MM231	SEE W148 RECEIVED JUL 10 2006 FACILITY STANDARDS	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 6 of 6 individuals (Individuals #1 - 6) residing in the facility. This had the potential to negatively impact individuals' health. The findings include: An environmental review, conducted on 6/1/06 at 9:05 a.m., showed the following concerns: Kitchen: - The silverware tray had food particles and hair	MM380	MM380 1. Silverware drawer, the oven, dusting blinds, pepper in the cupboard, and the muffing tin will be addressed through staff training. Theses are issues that are on the cleaning list for the homes and should be being done on a weekly basis or as spills occur. Staff training will occur and each staff reminded of how and what to do to keep the home looking nice at all times. The dresser tops and the broken blind will be assessed by the maintenance personnel and repairs will be done as needed. At the day program the ink smear, dirty sinks, dirty floor, black marks on the walls, splatters in the microwave, and crumbs in the silverware drawer will be addressed through staff training. Theses are issues that are on the cleaning list for the center and should be done on a daily basis or as spills occur. Staff training will occur and each staff reminded of how and what to do to keep the center looking nice at all time. Therapy wedge will be assessed and repaired and/or replaced as needed. Paint on all wall will be repaired as needed. 2. Repairs are to be reported to the administrator as they occur.	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7-5-06

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MM380	Continued From page 1 in it. - The cupboard above the paper towel holder had spilled pepper on the shelf. - There was burned on food in the oven. - A muffin tin had burned on grease on it. Individual #1's Bedroom: - The cord to open and close the blind was missing. - The slats on the blind were dusty. Individual #2's Bedroom: - The window sill was dusty. - The top of the 5 drawer white dresser was missing paint. Individuals #5 & 6's Bedroom: - The windowsill was dusty. - Both of the 5 drawer dressers were missing paint. Individual #4's Bedroom: - The blind slats were bent or broken. An environmental survey of the facility's day program, conducted on 6/1/06 at 10:15 a.m., showed the following concerns: The orange physical therapy wedge had 3 hole on it approximately 1 inch in diameter. There was an ink smear, approximately 2 feet long, on the outside wall of the work area. Restroom #3 was missing paint above the sink, exposing bare wood an uncleanable surface. Restroom #2 had an unidentifiable "glob" on the	MM380	3. When repairs are received in the office they are given to the maintenance personal to be done. 4. Once the repairs have been done the maintenance slip is given back to the administrator to indicate they are done. 5. All repairs will be completed by July 31. 2006	

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MM380	Continued From page 2 sink. Restroom #2's floor had numerous stains. Restroom #2's ceiling vent was covered with dust. Restroom #1's floor had numerous stains. The tile in the dining area had numerous pit and black marks on it. There were black marks and paint was missing under the window in the dining area. Both of the microwave ovens had food splatters. There were food crumbs in the silverware tray in the kitchen.	MM380		
MM673	16.03.11.250.07(b) Variety of Food Menus must provide a sufficient variety of foods in adequate amounts at each meal. Menus must be different for the same days each week and adjusted for seasonal changes. This Rule is not met as evidenced by: Refer to W479	MM673	SEE W479	
MM755	16.03.11.270.02(f)(ii)(a) Resident unable to Self-Administrate If the resident is not capable of self-administration of medications under staff supervision, this fact must be documented in the resident's assessment. Such residents cannot be accepted by facilities unless a licensed nurse is on duty to administer and record such medications. This Rule is not met as evidenced by:	MM755	SEE W 370	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 (SUMMIT)	**3612 SUMMIT TRAIL IDAHO FALLS, ID 83402**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM755	Continued From page 3 Refer to W370	MM755		